MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M5-04-1750-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Insurance Co. of North America/Rep. Box#: 15 C/o ACE USA/ESIS P.O. Box 759 Houston, TX 77001	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		**CPT Code(s) or Description**	**Did Requestor Prevail?**
From	**To**		
8-25-03	8-29-03	Inpatient Hospitalization	☒ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The inpatient services were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

The Respondent denied Rev. Codes 120, 250, 251 272, 278, 300, 320, 329, 360, 370, 391, 412, 460, 480 and 710 with "F Reduction According To Medical Fee Guideline", "N Not Documented", and "M Reduced To Fair and Reasonable".

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 4 days. The operative report of 8-16-03 indicates the patient underwent "1. Right lumbar hemilaminectomy, foraminotomy and nerve root decompression L4-5. 2. Left lumbar hemilaminectomy, foraminotomy and nerve root decompression L4-5. 3. Right lumbar hemilaminectomy, foraminotomy and nerve root decompression L5-S1. 4. Left lumbar hemilaminectomy, discectomy, foraminotomy and nerve root decompression L5-S1. 5. Posterior lumbar interbody instrumentation (two Barantigan cages L4-5). 6. Posterior lumbar interbody instrumentation (two Barantigan cages L5-S1). 7. Posterior lumbar interbody arthrodesis L4-5. 8. Posterior lumbar interbody arthrodesis L5-S1. 9. Posterior lateral arthrodesis L4-5. 10. Posterior

lateral arthrodesis L5-S1. 11. Harvesting right posterior iliac crest morselized autograft through a separate fascial incision. 12. Insertion of lumbar epidural catheter at L2 for postop pain management." Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed $77,768.00 for the implantables. The carrier paid $20,122.30 for the implantables. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor provided the Commission with documentation on the actual cost of implantables, $18,293.00

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to
$36,586.00.

The audited charges for this admission, excluding implantables, equals $75,625.58. This amount plus the above calculated audited charges for the implantables equals $112,211.58 the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to $62,907.69 ($84,158.69-$21,251.00 (amount paid by respondent).

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is entitled to a reimbursement amount for these services equal to $62,907.69.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of $650.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of $62,907.69, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Allen McDonald	7-21-05
Authorized Signature	Typed Name	Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MEDICAL REVIEW OF TEXAS

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-1750-01
Name of Patient:	
Name of URA/Payer:	Vista Medical Center Hospital
Name of Provider: (ER, Hospital, or Other Facility)	Vista Medical Center Hospital
Name of Physician: (Treating or Requesting)	Mark McDonnell, MD

May 3, 2004

An independent review of the above-referenced case has been completed by a neurosurgeon medical physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

The patient is a 38-year-old male injured on the job ___. He had subsequent back and leg pain and was treated conservatively without improvement. He was noted to be neurologically intact. MRI showed desiccation of the L4-5 disc. Discography revealed a complete annular tear at L4-5 with concordant pain at L5-S1. He was taken to surgery 8/25/03 for interbody and posterolateral fusion with instrumentation and iliac crest bone grafting with the use of platelet rich plasma.

REQUESTED SERVICE(S)

1. OR Code 361 – use of platelet rich plasma and iliac crest bone grafting
2. OR Code 270 – OR supplies

DECISION
Approved.

RATIONALE/BASIS FOR DECISION

1. It is common practice in the spinal surgery community to use either autologous (platelet rich plasma) or exogenous (bone morphogenic protein) growth factors along with autograft to achieve the maximum fusion rate. Both platelet rich plasma and bone morphogenic protein have been shown to enhance fusion rates. Frequently, the volume of growth factors is insufficient to fill the fusion bed and therefore iliac crest autograft or graft extender may be indicated.
2. The supplies listed as OR Code 270 do not seem to be excessive for a posterolateral/interbody fusion with instrumentation procedure.